



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

HOUSTON ORTHOPEDIC & SPINE HOSPITAL
5420 WEST LOOP SOUTH #3600
BELLAIRE TX 77401

Respondent Name

TX PUBLIC SCHOOL WC PROJECT

Carrier's Austin Representative Box

Box Number 01

MFDR Tracking Number

M4-12-2869-01

MFDR Date Received

MAY 11, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Pt gave BC for insurance information. Once BC paid 10/13/10 we then billed pt. who would not response [sic] to her bill. Pt called 2/18/12 stated with was w/c and gave the correct billing information. Payment is due by creative risk. We have 95 days from the day we are notify."

Amount in Dispute: \$818.98

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "On February 24, 2012, CRF received a medical bill from Requestor for treatment rendered to Claimant at its facility on September 4, 2010. On March 12, 2012, CRF denied Requestor's bill on the grounds that the time limit for filing the bill had expired...Notwithstanding Requestor's representation, the attached evidence reflects that Claimant underwent spinal surgery at Requestor's facility on August 26, 2010. This surgery was preauthorized through workers' compensation channels on July 27, 2010 and Requestor was identified as the facility for this procedure. Furthermore, on October 11, 2010, our office negotiated payment for the amount of Requestor's hospital bill (related to Claimant's surgery) with Suzanne Sharp, a representative of Requestor's business office. In light of the documentation, it is indisputable that Requestor had information apprising it of the workers' compensation nature of Claimant's treatment no later than October 2010."

Response Submitted by: Creative Risk Funding

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 5, 2010	CPT Codes 82552, 84482, 72125-TC, and 99283	\$818.98	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical

fee dispute.

2. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits

- 29-The time limit for filing has expired.
- 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- W4-No additional reimbursement allowed after review of appeal/reconsideration.

Issue

1. Did the requestor waive the right to medical fee dispute resolution?

Findings

28 Texas Administrative Code §133.307(c)(1) states: "Timeliness. A requestor shall timely file with the Division's MDR Section or waive the right to MDR. The Division shall deem a request to be filed on the date the MDR Section receives the request. (A) A request for medical fee dispute resolution that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute." The date of the services in dispute is September 5, 2010. The request for medical dispute resolution was received in the Medical Dispute Resolution (MDR) section on May 11, 2012. This date is later than one year after the date(s) of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307, subparagraph (B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

Conclusion

The Division finds that the requestor has waived the right to medical fee dispute resolution for the services in dispute. For that reason, the merits of the issues raised by both parties to this dispute have not been addressed.

Authorized Signature

_____	_____	10/03/2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.